



Health Matters

Summer 2011 • Issue 8

London Bridge Hospital New Consultant List

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Dr George Hallward	MBBS MRCP FRCA	Anaesthetics
Dr Christopher Langrish	BSc MBBS MRCP FRCA Dip ICM (UK) EDIC	Anaesthetics
Dr Thippa Raghuraman	MBBS MD DA DNB FRCA	Anaesthetics
Mr Anthony Aymat	FRCS (Otol) FRCS (Orl-HNS)	ENT Surgery
Mr Antony Jacob	FRCS (Otol) FRCS (Orl-HNS)	ENT Surgery
Dr Antonio Pagliuca	BA MBBS MA MRCP FRCP MRCPPath FRCPPath	Haematology/Oncology
Mr Adrian O'Sullivan	BSc BMedSci MD FRCSI (Gen Surg)	Liver Surgery
Dr Satish Jayawardene	BSc (Hons) MBBS (Hons) MRCP (UK)	Renal
Dr Michael Rose	MRCP MD FRCP MRC	Neurology
Mr Bahram Fakouri	MD FANCh	Neurosurgery
Miss Pari Mohanna	MSB BS (Hons) BSC (Hons) MD FRCS (Plast)	Plastic Surgery
Dr Muaaze Ahmad	MB ChB (Hons) MRCS	Radiology
Dr Monica Khanna	BSc (Hons) MBBS (Hons) MRCS FRCR	Radiology
Dr Praveen Peddu	MBBS MRCS FRCR	Radiology
Dr Zaid Naim Viney	MBBS FRCR MRCP	Radiology
Dr Paul Jackson	FFSEM (UK) FFSEM (Ire) DipSports MRCGP DRCOG MBBS	Sports & Exercise Medicine
Dr Catherine Spencer-Smith	MBBS DRCOG MRCGP MSc Sport Ex Med MFSEM (UK)	Sports & Exercise Medicine
Mr Benjamin Challacombe	BSc (Hons) MBBS (Hons) MRCS (Ed) MS FRCS (Urol)	Urology
Mr Zaid Hany	MSc MD FRCS	Vascular Surgery

Note: Please see our website or Referrers' Guide for contact details of all Consultants featured in this magazine or contact the GP Liaison Department on:
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A message from the CEO

Welcome to the summer edition of Health Matters Magazine, a unique opportunity for London Bridge Hospital to connect with GPs and update you on new ways we may be able to support you and your patients.

As some of you might be aware, 2011 is a significant year for London Bridge Hospital, as this year we celebrate our 25th Anniversary. I believe that we are justifiably proud of the achievements we have made in the past quarter of a century, and am confident the hospital will move from strength to strength in years to come.

Over the years, London Bridge Hospital has enjoyed many firsts within the private healthcare sector, from being the first private hospital in the UK to offer the revolutionary Transcatheter Aortic Valve Implantation (TAVI) procedure, to being the country's first private facility to publish our cardiac surgery outcomes. Likewise, ours was the first private hospital to offer the minimally invasive Endobronchial Ultrasound (EBUS) procedure to patients requiring a lymph node biopsy, and our Consultants and hospital staff continue to research and innovate, ultimately striving to find ways to better care for your patients.

We are as aware as you are of the changes afoot in the NHS and how these are sure to affect you and your colleagues in your surgeries. As ever, our GP Liaison Team will assist you wherever they can with making adjustments to your working practices as you adapt to these changes. To that end, this issue of Health Matters includes articles which we hope will help you in this uncertain, transitional period. Your feedback is tremendously valuable to us, and if there is any further way in which you feel London Bridge Hospital may be able to support you and your colleagues – and, by extension, improve the care we can provide to your patients – we would of course be delighted to hear about it.

We feel lucky to enjoy the positive relationship we have with our referring GPs, without which we would not have been able to expand London Bridge Hospital to offer the wealth of services available to your patients today. Your continued involvement in the hospital is key to its success, and we look forward to working with you over the next 25 years.

I do hope you enjoy this magazine and thank you as always.

With kind regards and best wishes.

Yours sincerely

John Reay
Chief Executive Officer



John Reay
Chief Executive Officer



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London Bridge Hospital Development Update

Following the opening of two new operating theatre suites in 2010, London Bridge Hospital's major redevelopment project continues to progress. The redesign of the hospital's main reception has been completed, as has the first of two state-of-the-art catheter labs, with the second due to be operational by early summer 2011. As part of the necessary bed

expansion plan, demolition work has now begun prior to building into the hospital's atrium from the south side. Work is on track for the project to be completed by spring 2012.

Due to ongoing refurbishments, lifts on the east side of the hospital will not be operational during construction of the new Critical Care Unit. London Bridge Hospital apologises for any

inconvenience caused and all efforts will be made to keep noise levels to a minimum until the development project is complete.



Same Team, New Time

At London Bridge Hospital, it is one of our goals to make it as easy as possible to access the services we offer, be it for patients, Consultants or GPs. Due to increasing demand, the GP Liaison Department has recently extended their opening hours to 6.00pm.

London Bridge Hospital's GP Liaison Department liaises with GPs, Consultants, their secretaries and patients to provide appointments at London Bridge Hospital and its diagnostic and treatment centres. The service provides GPs with rapid access to appointments with our leading teaching hospital specialists with just one phone call.

London Bridge Hospital's Marketing & GP Liaison Manager, Manuela Bernhard, says, "The extended opening hours will play an important role in continuing to make booking appointments with GP Liaison as easy as possible. We are constantly reviewing ways to make life as simple as possible for GPs given their busy schedules."

Services are now available 8.30am to 6.00pm, Monday to Friday. If you would like more information about the GP Liaison Department, please call:

T: 020 7234 2009 or email
gpliaisonlbh@hcahealthcare.co.uk



London Bridge Hospital Celebrates its 25th Anniversary

London Bridge Hospital has been delivering high quality healthcare since 1986, when the hospital opened as St Martin's Healthcare in the current main hospital building. Over the years, the hospital has grown in stature, becoming part of HCA International Ltd in 2001, now the largest private medical provider in London.

Today, London Bridge Hospital is a world-renowned centre of private medical excellence, providing over 30 specialist services, including cardiac services, hepatology and oncology and treats patients from around the world.

London Bridge Hospital is renowned for bringing innovative, cutting-edge services and treatments into the private sector. Recent state-of-the-art procedures now available at the hospital include: live-related liver transplants, brachytherapy for the mapping and treatment of prostate cancer and the use of the Hansen Robot™ to aid complex cardiac procedures. We have also expanded our Interventional Radiology (IR) technology for rapid diagnosis and minimally invasive treatments.

As the treatments carried out at London Bridge Hospital become increasingly complex, the hospital has needed to grow. Currently part-way through a major £15million development project, the hospital has already gained a new dialysis unit as well as two new state-of-the-art theatre suites equipped with the latest equipment and clinical software, enabling our Consultants to perform more complex procedures. The project will see the hospital's bed count rise to over 140, with the Level 2/3 Critical Care Unit increasing to 15 beds. These advanced facilities allow us to extend our surgical and treatment services for patients with acute clinical needs.

With the extensive number of theatre cases undertaken at London Bridge Hospital, it is crucial to have an advanced perfusion department. London Bridge Hospital currently runs the largest private perfusion department in the UK, with one of the most integrated academic perfusion training programmes. Our Clinical Perfusion Scientists are at the forefront of developing point-of-care testing facilities and coagulation profiling

including intraoperative cell salvage, intraoperative fibrant sealant and platelet mapping.

London Bridge Hospital also continues to invest in the expertise and proven knowledge of our hospital staff. This includes specialist Consultants and surgeons who also work at London's leading teaching hospitals. We also continue to invest in Clinical Nurse Specialists and Chartered Physiologists to ensure that our integrated hospital services extend across all areas of patient recovery and rehabilitation.

Now occupying a total of five buildings as part of the main site on Tooley Street, the hospital is able to offer a comprehensive range of healthcare services in comfortable surroundings, with views overlooking the River Thames and Tower Bridge. The hospital has expanded further in recent years, now operating a total of five outpatient diagnostic and treatment centres – 31 Old Broad Street, Docklands Healthcare, Brentwood Medical Centre, Sevenoaks Medical Centre and City of London Medical Centre.

London Bridge Hospital
CELEBRATING **25** YEARS OF PRIVATE HEALTHCARE EXCELLENCE

Use of Non-Invasive Cardiac Imaging in the Assessment of Chest Pain

The assessment of new onset chest pain can be challenging. It is stressful for patients with the potential sequelae of the diagnosis of significant coronary artery disease and the resultant consequences. It is important to reach the correct diagnosis rapidly and not to miss a presentation of potentially significant coronary artery disease.

Invasive coronary angiography, the gold standard for the detection of coronary artery disease, provides anatomical rather than a functional assessment of coronary artery disease. It has a small but significant risk of important complications. To address these issues, several non-invasive functional tests have been developed for the assessment of chest pain. These investigations have now virtually replaced routine treadmill exercise testing in patients with chest pain. Patients with a low-risk factor profile will generally require a CT coronary angiogram. Those with slightly higher risk usually require some form of functional non-invasive cardiac imaging. This can be either nuclear imaging, cardiac MRI (also known as CMR) or stress echocardiography.

Cardiac MRI offers a safe method to assess the majority of these patients. Unlike nuclear imaging, the patient does not receive ionizing radiation. Images are readily obtainable in most patients in a 30-minute assessment. Cardiac MRI offers the most accurate assessment of left and right ventricular function. It allows

for direct visualisation of myocardial scarring or fibrosis, such as previous myocardial infarction. Detection of significant coronary artery disease is performed using adenosine stress perfusion imaging. Cardiac MRI is safe and well-tolerated by almost all patients. There are regular weekly Cardiac MRI sessions at London Bridge Hospital including stress perfusion imaging.



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Dr Mark Westwood was educated at St John's College, Oxford and St Bartholomew's Hospital, London. His interest in Cardiac MRI (CMR) started in 2001 with his MD thesis on CMR. He has been a Consultant Cardiologist at The London Chest Hospital for three years. During this time as Lead Clinician for CMR at The London Chest Hospital, he has initiated, set up and developed the CMR service into one of the largest UK CMR services, with a particular focus on the assessment of coronary artery disease with the use of CMR stress perfusion.

He is a Board member of the British Society of Cardiovascular MRI. He co-founded 'London CMR', the first UK clinically focused CMR meeting and now the second largest. He was central to the development of the training programme for cardiology trainees in the UK and is involved at national and international level in the delivery of training and education in CMR.

Dr Mark Westwood is available for outpatient consultations at 31 Old Broad Street, every Thursday afternoon.

Long-Term Back Pain

Dealing with longer-term back pain is a common problem among primary care physicians. While back pain resolves over a six-week period for most patients, some inevitably advance to spine surgery. When spinal surgeries fail, patients may suffer from Failed Back Surgery Syndrome or FBSS. These patients present with chronic back pain and neuropathic leg pain and should be referred to a pain specialist; for carefully selected patients, spinal cord stimulation may be proposed as a pain management modality.

Conventional Spinal Cord Stimulation (SCS) systems have been implanted regularly over the past 40 years to address the pain experienced by FBSS patients. Implantation typically involves the use of needle introducers to place two lead wires into the epidural space. The lead wires are connected to an implanted pulse generator placed within a subcutaneous pocket, much as a pacemaker would be.

Moderate relief of leg pain with little or no effect on back pain has been the norm until recently. Conventional SCS systems produce paraesthesias that serve to mask the sensation of pain in the region. While paraesthesia itself is considered irritating by most patients, it is nonetheless preferable to pain.

An SCS system that overcomes these two major shortcomings has recently become available. Dr Adnan Al-Kaisy, Consultant in Pain Medicine at London Bridge Hospital, indicated, "I've been evaluating a novel SCS System (Nevro Corporation, Menlo Park, CA USA) as part of a clinical research trial and I've been quite impressed with the results. The system's ability to address back pain is unparalleled and there have been no paraesthesia-related complaints. On average, we've observed 88% relief of leg pain and 74% relief of back pain with the Nevro System." According to Dr Al-Kaisy, comparable studies with conventional SCS systems report only 47% and 25% pain relief, respectively.

Dr Al-Kaisy plans to continue his research efforts and to offer the Nevro System to the back pain patients in his practice for whom it is indicated. The Nevro System has received the CE mark and is available for implantation following the standard period of trial stimulation. According to Dr Al-Kaisy, approximately 80% of the patients who undergo an SCS trial go on to permanent system implantation.

Dr Al-Kaisy holds clinic and theatre slots at London Bridge Hospital on Mondays. Ad hoc appointments are available on request. For further details, please contact Dr Al-Kaisy's secretary, Anne Whitehead:
T: 01795 530 530 or email t.t.whitehead@btinternet.com

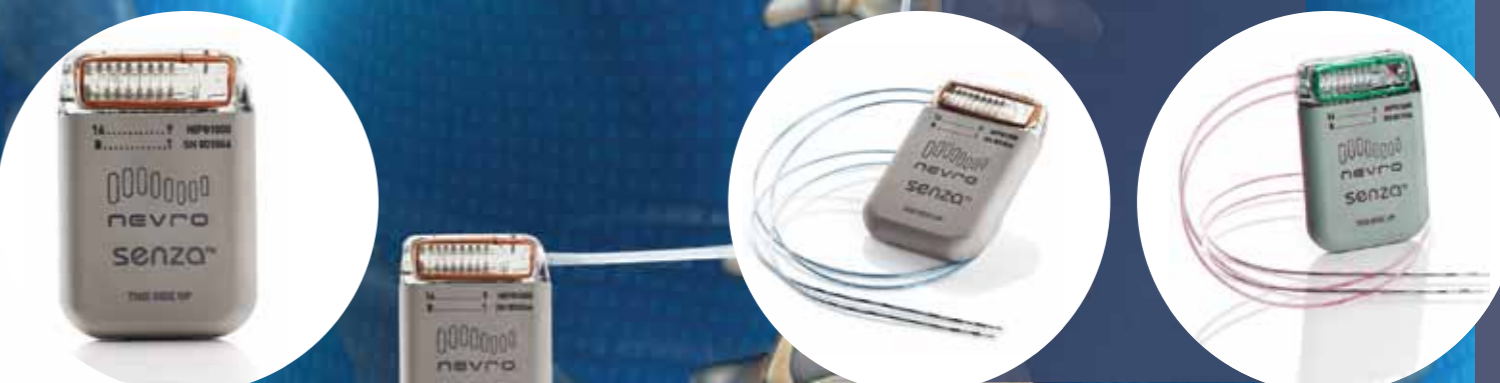
Dr Al-Kaisy
 MB ChB FRCA FFPMRCA FIPP
 Consultant in Neuromodulation
 and Pain Medicine



Dr Al-Kaisy is currently Clinical Lead and Consultant in Pain Management at Guy's and St Thomas' Hospital. He trained in Chronic Pain Medicine at The Walton Centre, Liverpool, for Neurology and Neurosurgery. He has a fellowship in Chronic Pain Management at University of Toronto Hospital, Canada.

He has a number of publications and research in a variety of categories in pain management. His interest is in management of Spine and Neuropathic pain. He has extensive experience in Neuromodulation: spinal cord stimulation for Failed Back Surgery Syndrome, intractable angina, nerve lesion and sacral nerve stimulation for urinary incontinence, interstitial cystitis and bowel incontinence.

Dr Al-Kaisy was voted the Hospital Doctor of the Year in 2001 for Pain Management.





Dr Daniel Baron MB DSportMed FFSEM (UK)
Sports Medicine Consultant

Dr Daniel Baron is a Sports Medicine Consultant at London Bridge Hospital and Associate Sports Medicine Specialist in the Department of Trauma & Orthopaedics at King's College NHS Foundation Trust.

The London Bridge Hospital clinic is on 1st Floor, Emblem House. Clinic information is available from Deanna Lee, PA, on: **T: 020 8852 4679**

**THE KT1000™
ARTHROMETER**

The KT1000™ arthrometer (MEDmetric Corporation, San Diego, California) was first introduced in clinical practice in 1982, following research and development led by Dr Dale M Daniel MD at University of California. It is the most used and most accurate portable knee ligament assessment system manufactured and I purchased my first arthrometer in 1992, which is still being used in my NHS clinic at King's College Hospital. I upgraded to the London Bridge Hospital model in 2005.

While there are other knee laxity systems, these can be complex to set up and use, especially in clinical practice, and two such systems can only be used effectively by knee kinematicians in research environments. The KT1000™ arthrometer avoids radiographic technique and exposure and can be used as part of the routine clinical knee evaluation. I attended the first special seminar on knee arthrometry, which was included in the European Society of Sports Traumatology, Knee Surgery and Arthroscopy (ESSKA) Congress in Oslo in June 2010 and provided data for discussion.

The KT1000™ measures anterior and posterior tibial translation while controlling rotation forces and can therefore assess Anterior Cruciate Ligament (ACL) and

Posterior Cruciate Ligament (PCL) injuries. Its portability has enabled me to use this in professional soccer and rugby, and over 19 years I have established reliable and reproducible testing techniques while understanding the intricacies of knee biomechanics. The arthrometer is easily applied with 5-10min exam time. An audible tone defines the designated force applied in tibio-femoral displacement. The knee flexion angle is noted and re-used for subsequent exams. A PCL Pro device allows varying flexion angles to measure PCL laxity.

Knee kinematics is important to appreciate. At shallow flexion angles, typically 20-30°, an active quadriceps contraction (AQD = displacement) will produce an anterior tibial translation 1-2mm in an ACL-intact knee. At deep flexion angles, typically 90°, an active quadriceps contraction will produce a posterior tibial translation 1-2mm in a PCL-intact knee. I determine the angle at which there is neither anterior nor posterior translation and this is termed the 'quadriceps neutral angle'. The two bands of the ACL can be assessed at 20-30° flexion, although the posterolateral band controls more rotation and the anteromedial band more translation. The two bands of the PCL also have different functions. At 90° the anterolateral band is assessed and injury results in the classic 'tibial drop back'. However, the posteromedial band is tight at 15° flexion and partial or interstitial injury can only be assessed at this relative shallow flexion angle. Failure to do so can result in missing these important injuries and I presented an award-winning paper at the EFOT meeting in Madrid 2004 on this subject.

**HOW DO I USE THE KT1000™
ARTHROMETER?**

In ACL injury, I use it in the sub-acute and chronic setting. It is possible to differentiate a partial from complete tear and we now know that up to 63% of partial tears heal. I can confirm a stable knee in presence of meniscal tear providing there isn't a bucket-handle component blocking potential knee motion. Serial assessment is possible in conservative care setting and measurements pre and post ACL reconstruction provide important outcome measures and used as part of

KT1000™ Arthrometry in Knee Ligament Injury

the International Knee Documentation Committee (IKDC) recommendations for minimum two-year follow-up together with Lysholm and Tegner scores. In regard to PCL injuries, serial assessments in conservative care are important as most of these injuries occurring in sports are interstitial or partial. In 2011, we still do not have an accepted international management protocol for PCL injuries. In all assessments, the patient is reassured and given hard evidence of progress and outcome. The arthrometer accuracy is periodically confirmed by 'accuracy' and 'linearity' tests.

WHAT AM I MEASURING IN CRUCIATE LIGAMENT INJURY?

In ACL injury, I measure Anterior Tibial Translation (ATT) at 67N and 89N. The difference is normally 1mm and the manual maximum should be <12mm. The involved (I) and non-involved (N) difference (I:N) is critical.

DISPLACEMENT	PREDICTION
>3mm I:N @ 89N	ACL deficiency 94% chance
>5mm I:N + >200hrs/yr IKDC I	Recommend ACL reconstruction
>12mm ATT man max	Flexion rotation drawer +ve
>18mm man max	Functional disability in ADL
>18mm	Rehab failure

In PCL injury, I measure passive Posterior Tibial Translation (PTT) @ 89N and compare this translation to that of the non-involved knee at the Quadriceps Neutral Angle (QNA).

DISPLACEMENT	PREDICTION
3-5mm @ 89N 20° flexion	Interstitial PCL injury
1-3mm I:N 20° - same 90°	Interstitial or partial PCL injury
5-7mm @ 89N ipsilateral	Consider surgery if combined
>7mm @ 89N ipsilateral	Surgery even if isolated

**WHEN CAN'T I USE THE KT1000™
ARTHROMETER?**

In an acute knee injury there is pain and likely inhibition and it is unreasonable to contemplate forced passive motion. There may be motion deficit and partial locking. The presence of joint effusion prevents the

patella engaging the trochlear groove and the patella has to be 'fixed' for the exam procedure. Therefore, patella pain and apprehension may preclude exam. Small adults and children have short tibiae and the arthrometer may not fit comfortably. One must beware a bucket-handle meniscal tear blocking potential knee motion.

CLINICAL EXAMPLES

VL was an 18-year-old female dancer with knee giving way in active daily living. She had no haemarthrosis and was noted to be hypermobile with loose knees. She had normal knee laxity profile on clinical exam. Magnetic Resonance Tomography (MRT) showed ACL oedema and arthrometry confirmed her abnormal Compliance Index (CI) but no significant side:side difference. She was given a rehab programme and did well on follow-up.

VL KT1000™ 25°	67N	89N	CI	MAN MAX	AQD	PTT
Involved mm	8	11	3	13	4	2
Non-involved mm	8	10	2	12	3.5	2

KG was a 24-year-old female netball player who presented with chronic knee injury eleven months post ski fall. She had been treated for MCL sprain. On return to sport, she had instability episodes. Her Lysholm score was 77 fair and Tegner activity score three with desired level seven. Clinically, her knee showed ACL laxity and functional exam revealed pathological hop test. MRT confirmed proximal ACL disruption.

KG KT1000™ 25°	67N	89N	CI	MAN MAX	AQD	PTT
Involved mm	8	10	2	13	5	2
Non-involved mm	5	6.5	1.5	7.5	1.5	2

She was referred for ACL reconstruction and at six months post op her graft stability was confirmed and she soon returned to sport with confidence.

KG KT1000™ 25° +6mm	67N	89N	CI	MAN MAX	AQD	PTT
Involved mm	6	7	1	9	2	2
Non-involved mm	5	6.5	1.5	7.5	1.5	2

TH was a 35-year-old male rugby fly-half who had frontal contact knee injury with

haemarthrosis, intact ACL laxity profile, no sag at 90° but posterior tibial translation discomfort 15° suggestive of interstitial posteromedial band PCL injury. MRT confirmed interstitial PCL tear and bone bruising.

At 14 weeks status post injury, his PTT was 2.5mm v 1.5mm N @ 15° and 2mm @ 90° v 1mm N. He was given a rehab programme and returned to sport at 22 weeks with no sequelae.

CONCLUSIONS

The ideal side:side differences in tibial translation have been established for many years and it is the difference between the bad and the good knee which should determine definitive patient management, and not just focus on the injured knee. A 3.5mm difference in anterior tibial translation has been deemed the critical level. At the ESSKA Congress in Oslo, a special ACL seminar findings concluded that a difference of >4.5mm in a symptomatic patient (knee instability) was even more critical and that symptoms beyond five months would result in knee kinematics never returning to normal whatever subsequent treatment is undertaken, including late reconstruction.

Accurate measurement of knee laxity in relation to ACL injury especially is therefore essential. I have found the KT1000™ arthrometer easy to use with reproducible measurements on follow-up exam. Patient selection and set up are important and these measurements are part of the IKDC recommendations for cruciate ligament care. Knee scanning is not necessary to determine whether an ACL or PCL injury has occurred as the exam and arthrometry does this. I use MRT to ensure that there is no associated injury, which either requires surgical attention or may hamper an otherwise intended rehab programme. A select few knee orthopaedic surgeons ask me to assess their patients pre and post op and for decisions regarding whether surgery is deemed necessary. All patients should have this benefit and have defined scientific outcome measures for their injury. I am in my 20th year of using the arthrometer, unparalleled in the UK, and have had excellent results with sub-acute and chronic injuries and in conservative and operative care.



With improved techniques, camera systems and equipments, previously difficult procedures are now possible

Use of Arthroscopy in Upper Limb Surgery

With increasing use of arthroscopy in orthopaedic surgery over the last few decades, it was inevitable that the technique initially established in knee surgery would become more widely used in upper limb joints (shoulder, elbow, wrist and hand). With improved techniques, camera systems and equipment, previously difficult procedures are now possible. This is a brief overview of the role of arthroscopy in some of the more common upper limb conditions.

SHOULDER SURGERY

Arthroscopic shoulder surgery is one of the most common, successful and safe orthopaedic surgical procedures undertaken. Arthroscopic subacromial decompression is very successful in relieving the pain of rotator cuff tendonitis and allowing a return to daily activities and sports. The recovery is usually rapid and incidence of any post-operative complication is low. Arthroscopy is also used in performing rotator cuff repairs, debridement of calcific tendonitis, stabilisations, capsular release for chronic adhesive capsulitis (frozen shoulder), acromioclavicular joint stabilisation for traumatic dislocations and debridement of degenerative and septic joints. (See Fig. 1)

ELBOW SURGERY

In the elbow joint, the technique is now established and it is feasible to remove loose bodies, deride the degenerative joint including removal of osteophytes, perform a capsular release

in stiff elbows to regain movement, excise radial head, synovectomy and arthroscopic release of tennis elbow and related soft tissue pathologies. (See Fig. 2)

WRIST SURGERY

Wrist arthroscopy is a developing and useful technique. With limited morbidity, it permits a substantial number of technical procedures in a range of areas, from fractures to the treatment of ganglions. It is a useful modality in diagnosing some of the more difficult wrist conditions that are not otherwise easily identifiable by imaging modalities. It is used in staging and grading of wrist pathologies which can alter the final management pathway. It is often used in traumatic injuries as in wrist and scaphoid fractures. It can be used in treating wrist ligament injuries including ligament reconstructions and repair of the wrist meniscal (TFC) injuries. Additionally, treatment of wrist arthritis can be carried out. (See Fig. 3)

HAND SURGERY

In hand surgery, the use of arthroscopic techniques is still in early stages and less developed. However, it is already used in treatment and assessment of base of thumb arthritis, in particular in early stages where conservative measures have failed and the patients are too young for more aggressive treatment options.

Fig. 1
A completed arthroscopic rotator cuff repair.

Fig. 2
A loose body in the elbow joint.

Fig. 3
Midcarpal view of a scaphoid non-union with the associated chondral damage.



Fig. 1

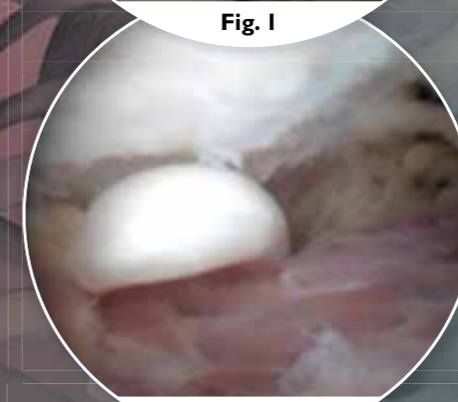


Fig. 2



Fig. 3

Mr Adel
Tavakkolizadeh

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Mr Adel Tavakkolizadeh studied medicine at the Royal London Hospital graduating in 1995.

His Orthopaedic Registrar training was at Guy's and St Thomas' Hospital rotation. He has completed two fellowships including a sports medicine and upper limb surgery fellowship in Perth, Australia, followed by a year of upper limb surgery (shoulder/elbow/wrist/hand) at King's College Hospital. He has been working as a Consultant Orthopaedic and Upper Limb Surgeon at King's College Hospital since 2008.

He provides a comprehensive upper limb surgery service, including minimally invasive and arthroscopic shoulder and elbow procedures. He also treats all wrist and hand conditions, including fractures and soft tissue injuries.

Mr Tavakkolizadeh is actively involved in both postgraduate training as well as in research.

He is a faculty member in several educational and skills courses and participates regularly in GP and physio teaching programmes.

Tackling the rise of RSIs

A New Multidisciplinary Approach

Repetitive Strain Injury (RSI) is a term used to describe a broad range of symptoms caused by the repeated movement of a particular part of the body. RSIs are also known as Work-Related Upper Limb Disorders (WRULD), Repetitive Stress Injury and Cumulative Trauma Disorder. It usually affects the upper limb (shoulder, elbow, wrist or hand) and can be caused by any repeated activity including sports and pastimes, affecting up to 500,000 people per year.

However, the most common association made with RSI is through work, as this is where we spend the majority of our time. The past year has seen an almost 10% increase in symptoms of RSI, costing employers an estimated £5-£10bn in lost productivity.

Out of the office, recent advances in technology – smartphones, handheld videogames, even hair-straighteners – have led to a new wave of RSI problems. This demonstrates how even the most entertaining or labour-saving gadget might be causing an RSI which can develop into a chronic problem.

There have always been difficulties in treating these conditions. Firstly,

these conditions are sometimes longstanding, having been initially left by the patient (“I thought it was just a sprain and that it would go away on its own”). Also, these conditions are cumulative and patients often finally present with an array of symptoms. This mix of syndromes therefore needs deconstructing in order to make accurate diagnoses so that treatment for each can start. Finally, for many of these problems to be accurately assessed, diagnosed and effectively treated, several specialists may need to be involved – including the GP, an orthopaedic surgeon, physiotherapists, a hand therapist, a pain specialist, a psychologist and even a vocational rehabilitation specialist.

Unfortunately, liaising between these teams has always been the job of the patient or the GP and the complexity of keeping track of treatment can lead to miscommunication, delays and lack of progress.

RSI TYPE 1 AND TYPE 2

Type 1 conditions include well-defined syndromes such as Carpal Tunnel Syndrome, DeQuervain's Tenosynovitis,

Mr Tony Kochhar
Consultant Shoulder and
Upper Limb Surgeon



Cubital Tunnel Syndrome, Olecranon Bursitis and Ganglion formation. These conditions may be due to, or be made worse by, repetitive tasks. These syndromes may have other symptoms such as swelling, inflammation, nerve compression problems, etc.

Type 2 RSI conditions are less specific. These tend to present as deep, non-specific aching pains and episodes of tingling and neurogenic pain symptoms that are difficult to define. Recent studies suggest that repetitive movements cause traction on peripheral nerves leading to these symptoms. Other research suggests that these conditions are myofascial in origin.

COMMON CAUSES OF RSI

- Continued repetitive actions
- Vibrating equipment
- Cold temperatures
- Poor posture or holding the same posture on a continued basis
- A badly-organised work area
- Prolonged periods of work without a break
- Stress or fatigue
- Carrying heavy loads on a repeated basis

TIPS TO PREVENT RSI

- Take regular breaks from repetitive tasks
- Stretch regularly – stand up to stretch if you can
- Try not to slouch and hold a good posture. Ideally, your head and back should form a straight line from your ears to your pelvis
- Reduce hot desking
- Use a laptop backpack not a satchel
- Make sure the height of your chair is correct and your desk is set up so that you do not have to repeatedly reach over
- When typing, try to keep your fingers pointing forwards – touch-type if you can to avoid using the same fingers over and over again
- If your job involves a lot of phone usage, try not to hold the handset between your ear and shoulder – use a headset if possible

CASE STUDY

Ms ME, a 33-year-old executive assistant in the City, presented with a 9-month history of bilateral wrist pain (right worse than left). An MRI scan confirmed clinical diagnosis of severe DeQuervain's Tenosynovitis (Figures 1 and 2). Prompt treatment involved a focal steroid injection, splinting (Figure 3) and hand therapy. The patient had fully recovered within 6-8 weeks and has had no recurrence at 9 months.

The RSI Clinic at London Bridge Hospital has been set up with the specific aim of providing a comprehensive approach to treating RSIs. We believe in providing patients a seamless service across all specialties. Notes are shared and cases are commented on by all our specialists, with the aim of minimising the number of wasted appointments and maximising information sharing and effectiveness of treatment.

Fig. 1 & Fig. 2 – Coronal (1) and Axial (2) MRI images demonstrate severe swelling and surrounding inflammation of the extensor tendons confirming DeQuervain's Tenosynovitis.

Fig. 3 – Thermoplastic splint fitted by our specialist Hand Therapist at London Bridge Hospital.



Fig. 1

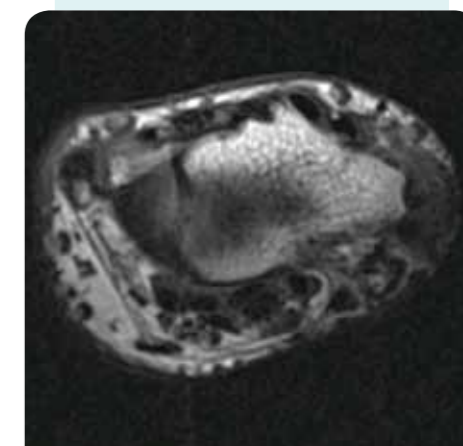


Fig. 2



Fig. 3

A Clinic for Blackouts and Dizzy Spells

Fits, faints, funny turns, dizzy spells; there are almost as many terms to describe such events as there are causes. In many cases the diagnosis is clear. However, sometimes the events are more difficult to fathom. It is well recognised that many patients are misdiagnosed, sometimes being inappropriately treated for years. This can obviously have a multitude of follow-on effects, not least the side-effects of medication, the stigma of a diagnosis (particularly when inaccurate) and the implications for driving and occupation.

These events are common clinical problems; perhaps 1% of all visits to the Accident & Emergency Department relate to variations on this theme and the situation is very similar in general practice. Furthermore, it has been estimated that at least 10% of unexplained falls in the elderly are caused by syncope associated with an element of retrograde amnesia.

The aetiology of these events can be cardiac, neurological or psychological; other events where consciousness is altered, for instance with coma or intoxication, make this area more complex, often requiring close collaboration between a number of medical specialties. Recently (August 2010) NICE published guidance on the management of this complex area under the term Transient Loss of Consciousness (T-LOC). International guidance is also available from the European Society of Cardiology, updated in 2009.

The diagnosis, while sometimes elusive, can often be made from a detailed history, a focused examination and simple investigations (e.g. lying and standing blood pressures, ECG). Prolonged heart rhythm monitoring can be very helpful. A 24-hour tape or a seven-day monitor may be sufficient depending on the frequency of the events. There are now implantable monitors, similar in size to a USB stick, which can monitor and document a patient's ECG for up to three years – even infrequent events can now be diagnosed! There are many other investigations which can be useful,

either cardiological or neurological – which ones to choose often becomes clearer after the initial assessment.

The new guidelines place special emphasis on the cardiological causes of blackout because of the association with sudden death and emphasise the need for the rapid assessment of patients to exclude the more worrying causes. 'Cardiac' causes can be divided into four main categories:

- Arrhythmias (brady- and tachyarrhythmias)
- 'Obstructive' lesions e.g. aortic stenosis, hypertrophic cardiomyopathy
- Orthostatic hypotension
- Vasovagal events/neurocardiogenic syncope, or simple faints

The first two groups are of considerable importance as they can be associated with a significant increase in sudden death, although extremely effective treatments are available.

Pointers to the more worrying causes of blackouts include:

- Occurring while lying flat
- Occurring while exercising
- Associated with palpitations
- In those with known structural heart disease (e.g. previous myocardial infarction) or with clinical signs of such
- With significant injury
- In those with a family history of sudden death under the age of 40
- In those over the age of 65 without a prodrome

The London Syncope Clinic aims to offer patients a rapid (within 24-48 hours) assessment of their blackout or dizzy spell. An initial review with a cardiac physiologist for an ECG and an echocardiogram is followed by a consultation with a Consultant Cardiologist with an expertise in the management of syncope. Further investigations, whether non-invasive or invasive can then be undertaken and onward referrals to other specialties can be made within London Bridge Hospital, thus allowing an integrated approach to patient care and as close as is possible to a one-stop clinic.

Dr Nicholas P Gall
MSc MD FRCP

Consultant Cardiologist and
Cardiac Electrophysiologist

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www.gallcardiology.com



Dr Nicholas Gall is a Consultant Cardiologist with a subspecialty interest in Cardiac Electrophysiology – the management of heart rhythm disorders. Dr Gall qualified from Guy's and St Thomas' Hospital in 1993 and after general medical training in London, joined the South East Thames Cardiology Training Scheme, gaining his CCST in 2003. He has been a Consultant Cardiologist at King's College Hospital since 2004, with additional time spent at Guy's and St Thomas' Hospital (part of King's Health Partners). He is also an Honorary Senior Lecturer at the University of London. While Dr Gall manages all aspects of heart disease, his subspecialty area is heart rhythm problems including radiofrequency ablation and device therapy (pacemaker, ICD and CRT). This area also includes the prevention of sudden cardiac death from inherited syndromes. His particular area of interest is in the management of blackouts, dizzy spells and related syndromes. This has led to the development of the Neurocardiology Service at King's, a joint venture between the two specialties to better manage patients crossing between the two areas. He is also Syncope Lead for the South East Thames Cardiac Network.



Cardiac Update

Mannitol Bronchial Challenge Testing

The Cardiopulmonary Centre at London Bridge Hospital is excited to announce the launch of a new service for the diagnosis of bronchial hyper-responsiveness. A test of particular interest to physicians for the differential diagnosis of asthma and hyper-reactive airway obstruction,

mannitol challenge testing is expertly performed by the centre's Respiratory Physiologists.

As an alternative to histamine challenge testing, this test makes use of progressively higher doses of the licensed drug Osmohale in the form

of powder capsules, with airway function assessed with spirometry and flow-volume loops. The mannitol testing protocol used within The Cardiopulmonary Centre offers a more streamlined challenge test which is well-tolerated by patients.

Referrals are welcomed from all specialties, with the option to have results reported by the centre's Consultant Respiratory Physician, Dr George Santis.

T: 020 7234 2265 for appointments.

Ambulatory Sleep Monitors

Overnight ambulatory sleep monitors for the diagnosis of sleep apnoea are available from The Cardiopulmonary Centre. These devices are particularly suited to those patients who are not candidates for in-hospital sleep studies or full polysomnography.

A simple screening tool, the Apnoea Link records fingertip oximetry, pulse, nasal flow and respiration within the comfort of the patient's own home. Although not strictly diagnostic, these monitors are quality screening tools in the diagnosis of obstructive sleep apnoea especially where CPAP therapy may be indicated.

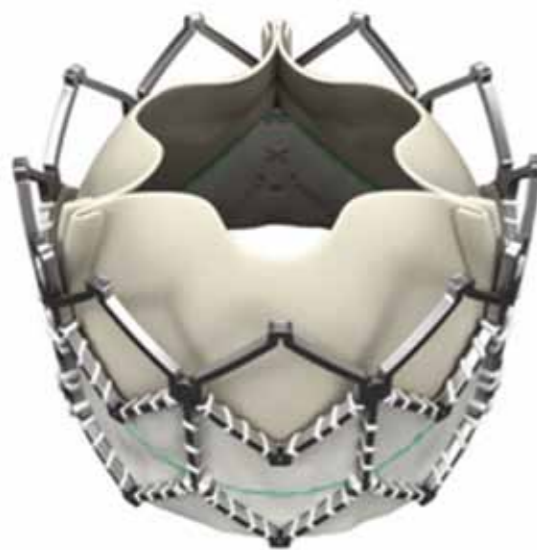
T: 020 7234 2265 for appointments.

New Procedures – Aortic Stenosis Treated with TAVI

Aortic Stenosis is common in the elderly and without treatment can carry a poor prognosis with a 2-year mortality as high as 50-60% with continued medical therapy. In addition, it also interferes with quality of life, resulting in a reduced exercise tolerance. This is due to shortness of breath and chest pain, along with pre-syncope or syncope episodes.

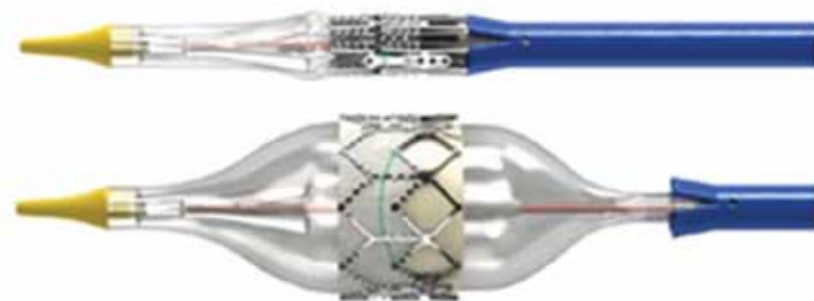
The standard treatment for this condition is surgical Aortic Valve Replacement (AVR). Although this can be a very successful operation in patients with no co-morbidity, in elderly patients with co-morbidities, it can carry a very high risk, often resulting in withholding of this therapy.

TAVI (Transcatheter Aortic Valve Implantation) is a very exciting innovation where the aortic valve is replaced without the requirement for open heart surgery or heart bypass. This new technique is catheter-based, where a balloon expandable valve mounted on a stent is delivered either retro-gradely via the femoral artery or ante-gradely, through a small incision at the apex, below the left breast.



The structure of the valve, which is sewn into a metallic stent.

The stent is compressed on a deflated balloon to allow it to be introduced through a 6-7mm sheath; it is then placed across the aortic valve and inflated in position.



SUITABLE PATIENTS

The procedure is currently restricted to patients considered high surgical risk, or those who have been turned down for conventional AVR. The selection of suitable patients is vital and involves a consultation with both a cardiologist and cardiac surgeon. The screening process usually involves a 1-2 day hospital stay and includes echocardiography, lung function, ultrasound of carotids, CT of aorta and peripheral vessels and coronary and peripheral angiography. Following this, an assessment can be made as to whether the TAVI procedure is suitable and, if so, the intended approach.

The decision to perform the procedure via the femoral artery or apex is largely down to the presence of peripheral vascular disease – if the ilio-femoral vessels are <7mm and/or significantly calcified or tortuous, the procedure may need to be performed apically.

THE PROCEDURE

The procedure is performed under general anaesthesia by a team including cardiologists, cardiac surgeons, echocardiographers and anaesthetists. It is performed either ante-gradely, via a 4-5cm incision at the apex to gain direct access to the left ventricle or retro-gradely via the femoral artery. In both approaches, a valvuloplasty is performed prior to introducing the valve mounted

on a balloon. After careful positioning with angiography and trans-oesophageal echo guidance, the balloon is inflated thus deploying the valve in the position of the patient's own aortic valve.

RESULTS

Worldwide, implants total greater than 20,000. The success rate of the procedure is approximately 97%. The predicted surgical mortality in these patients is >20% and the current trial data demonstrate that a 30-day survival of 95-96% can be achieved. Clinically, a marked improvement in symptoms and quality of life has been demonstrated and this appears to be maintained long-term.

Recently, a randomised trial (PARTNER A and B) of over 1,000 patients has been performed. The results were recently presented and published and show that, in patients deemed too high risk for surgery, TAVI is associated with a dramatic reduction in 1-year mortality compared to medical therapy (30% versus 50% respectively). In addition, in a separate arm of the trial, in patients felt to be high risk but suitable for open surgery, the two were found to be comparable in terms of mortality.

Although this is still a relatively new procedure, these results are highly encouraging and it is likely that over time, this therapy will become more widely available to younger and less high-risk patients.

AORTIC STENOSIS CASE STUDY – DR JEAN VASEY

“Around 10 years ago, I found I was having difficulty keeping up with my companions on successive walking holidays in Switzerland, the Pyrenees and Corfu. Over a decade, I had gradually increasing difficulty with slopes and golf due to fatigue and breathlessness. Previously, I had been told that I had a heart murmur, so I asked my GP to refer me to Dr Brian Gould, a cardiologist. He gave me a coronary angiogram at St Thomas’ and referred me to Mr Christopher Young at London Bridge Hospital with a diagnosis of severe Aortic Stenosis.

“Mr Young told me that my age of 85 was not really significant and that I could have a tried and tested open heart operation or the newer, less invasive, but less well tested, Transcatheter Aortic Valve Implantation (TAVI). Both were discussed and I chose the TAVI procedure.

“Professor Simon Redwood and the TAVI team carried out the procedure at London Bridge Hospital in March 2011. I underwent a transfemoral TAVI, using a 23mm Edwards Sapien XT valve. From the beginning, I felt very confident about everybody and pleasantly surprised that I was pain-free following the procedure. The nursing care in ICU and in my room was very good and expertly carried out by all the staff. I really enjoyed talking to all the various people I came in contact with.

“Mr Young told me that the shortest hospital stay after a TAVI was one day but agreed that person was not 85. After an excellent recovery, I was discharged on the fifth day feeling fine. I was pleased that, particularly during my initial consultations, both Mr Young and Professor Redwood were personally involved in my care plan, which I feel was an important factor in ensuring I felt confident about my treatment. I am very grateful to the cardiac team and all the TAVI staff at both St Thomas’ and London Bridge Hospital.”

The TAVI procedure is performed with close collaboration between an Interventional Cardiologist and a Cardiothoracic Surgeon. In this case, Dr Vasey's procedure was performed by Professor Redwood in conjunction with Mr Young. They have both been involved in over 200 procedures, with 10 of those being carried out at London Bridge Hospital – these have carried a 100% success rate.

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Cardiology at St Thomas'
Hospital and London Bridge
Hospital.

He is also Director of the
Cardiac Cath Labs at St
Thomas' Hospital and was
Treasurer and Council
Member of BCIS for 9 years.
He has extensive experience
in high-risk and complex
interventional procedures
including rotablation, laser,
chronic total occlusions, mitral
valvuloplasty and Transcatheter
Aortic Valve Implantation
(TAVI). Professor Redwood
runs an active interventional
research programme, details of
which can be found at [www.
cardiacresearchcentre.com](http://www.cardiacresearchcentre.com)

Current NHS Changes

How will they affect GP Practices?

Dr Michael Dixon
OBE FRCGP

Michael Dixon has been a GP in Cullompton, Devon for 26 years. He has been Chair of NHS Alliance, representing primary care, PCTs and practice-based commissioners, since 1998. His national roles also include chairing the National Life Check Board and being a member of the National Stakeholder Forum. He is a Senior Associate of the King's Fund and Honorary Senior Fellow in Public Policy at HSMC (University of Birmingham).

Other appointments include Visiting Professor to the University of Westminster (Integrated School of Health), President of the Health Writers' Guild and Honorary Senior Lecturer in Integrated Health at the Peninsula Medical School.

Not so many years ago, general practice was undervalued, GPs were relatively underpaid and the GP registered list was, itself, under threat. Meanwhile, GPs who wanted to improve local services or make a real difference to the health of their patients found themselves stonewalled and excluded from the corridors where decisions were made.

Today, general practice finds itself in an almost opposite situation. With Government recognising the crucial role of general practice and primary care in improving the health service and making it more cost effective, GPs are now less concerned about being excluded and more worried about the huge responsibilities that are coming their way.

These responsibilities are the result of the recent Health White Paper and the Health Bill currently going through Parliament. That this Bill is the largest (in terms of size and words) ever presented to Parliament is itself a mark of the huge changes to come in general practice. On the positive side, the Bill will enable every GP and GP practice to improve local health and services and extend our role from individual patient advocate to advocate of local health and the local population. Some believe that this enormous extension in our ability to help local patients comes at too high a price because our individual patient advocate role may be in conflict with our role as agent for the local population (doing the best for the greatest number). No one wants to be seen as an 'agent of Government'. In reality, however, the two roles should be mostly complementary in as much as GPs should have a better 'menu' of services to offer in the consulting room and overall more resources to offer each patient if they have been successful commissioners.

GP commissioning apart, two further factors will have an enormous impact on general practice over the next few years. The first is the Government's commitment

(continuing from the Blair days) to increasing competition and a larger influence of the market in health. The second is the financial recession, which will see GPs as commissioners and providers needing to make their contribution to the £20 billion that has to be saved over the next few years.

How will things be different for the average GP, practice manager or practice? Whether leaders or followers, we will all be able to have a say on local health initiatives and be able to put the problems in local services right. As future GPs, we will also need to have an eye on the best use of scarce resources. Individuals and practices who spend more on referrals, prescribing and diagnostics, will need to watch things closer than they do now. We will all have a vested interest in doing so (needing to be an entirely transparent vested interest, where it is personal and financial) and our patients will need to see themselves as interested parties in terms of making the best use of resources available.

Our everyday role in general practice as providers of care will also change in numerous ways. The most obvious change, over the next few months, will be a much closer working between those practices who form part of a GP consortium. The responsibility for quality improvement will be largely delegated to GP consortia by the National Commissioning Board and peer pressure between and within practices will become a far stronger force than previously. Quality, safety, access and costs will all be under review by our peer colleagues, who are likely to be quicker to identify and hopefully solve any problem areas. The positive side of this will be better and safer general practice but the downside will be threatening to those practices that don't match up or accept support to do so. The threat of expulsion from the consortium and loss of the practice's licence will be the worst option.

At the same time, practices will become far more transparent in terms of their performance measured by the Quality Framework and other measures. Patient involvement in practices (via practice patient groups and the like) will become standard as a means of showing the practice is listening to its patients. Such groups will also be a means of support, when difficult commissioning decisions need to be made. They may also be needed as regulation tightens its hand and GP practices fall under the Care Quality Commission.

As well as being more accountable, general practice will find itself in a more competitive environment. Thirty years ago, each general practice would watch what its competitors were doing and try to match them. Those days will return, especially with the opening of GP boundaries (proposed by both this and the former Government) and with private providers entering the market. The competition to provide and to show that you provide the best service as a commissioner and a provider and in terms of patient experience will become much greater.

Competition will encourage diversification. Just as the corner shop has given way to Tesco, patients are likely to want more services 'under one roof' with many practices offering 'GP plus' such as pharmacy services, Citizen's Advice, self-care and a range of different therapies. As commissioners, we are likely to want to bring an increasing range of previously hospital-based services into the community and general practice. This will offer further opportunities for diversification and offer increased income and stability for local practices though, once again, they will need to be absolutely transparent, where self interest is involved. In many cases, practices may overcome this by forming social enterprise or community interest companies that manifest their commitment to the local community.

In parallel with our role as health commissioners, future GPs and practices are also likely to be much more involved in providing health as well. In the shop window of each general practice there is likely to be a far greater emphasis on personal and community health and helping people to self-care. This will

hopefully be encouraged and funded by the Health and Wellbeing Boards of the Local Authorities. General practices ahead of the game will become demonstration sites for health – nutrition, exercise and improved wellbeing – working in closer contact with their local communities and other health-related agencies.

With our extended role, future GPs are likely to work even harder in a more challenging and complex environment. As far as patients are concerned, future general practice should be safer, better and more cost effective. Traditional values of general practice such as personal relationships and continuity may also be valued higher in a competitive environment, where the views of patients count more. For GPs, practice managers and other practice staff, life should be more satisfying because we will be able to do so much more. Our extended role should also enable us to retain status and income by being the most important and central cog in the NHS's future. That future, because of the current changes, will be largely in our hands.



Sleep Centre

A good night's sleep is essential for the maintenance of physical, mental and emotional wellbeing, with many sleep conditions leading to a vastly reduced quality of life.

London Bridge Hospital has recently set up a dedicated Sleep Centre to provide diagnostic observation and subsequent treatment for those patients who may be suffering from one or more of the symptoms below:

- Anxiety about sleep
- Dryness of the throat
- Excessive daytime sleepiness
- Excessive fatigue
- Excessive snoring
- Impaired daytime mental alertness
- Inability to wake
- Insomnia
- Poor quality sleep
- Witnessed apnoea episodes

OR

- Any nocturnal parasomnias, i.e. all unwanted sleep behaviours, such as sleepwalking, sleep talking, bruxism (teeth grinding), bed-wetting etc.

Sleep disturbances can also encompass a huge range of conditions such as:

- Narcolepsy
- Nasal/upper airways symptoms
- Nocturnal epilepsy/fits
- Obesity
- Obstructive Sleep Apnoea
- Parasomnias
- Snoring

The Sleep Centre works alongside Dr Guy Leschziner who reviews patients' results, helps diagnose a condition and prescribes the most effective treatment available. The tests that are undertaken at the Sleep Centre include:

FULL POLYSOMNOGRAM (PSG)

A full PSG is an overnight sleep study which provides an extensive analysis of sleep by charting a patient's breathing, heart rate, eye movements, leg movements, muscle tension and brain wave formations as the patient sleeps.

A full PSG is often used as a diagnostic test to look for sleep-related breathing disorders such as sleep apnoea. A PSG can also pick up and observe behaviours during sleep which could ultimately be harmful for the patient or those around them, for example violent episodes or sleepwalking.

MULTI SLEEP LATENCY TEST (MSLT)

An MSLT can also be called a 'nap study'. This test is used to identify how quickly the patient falls asleep in a quiet daytime situation. A patient who experiences excessive sleepiness would be classed as a person who constantly feels sleepy in situations in which you should 'normally' be awake and alert.

An MSLT test is primarily used to evaluate patients who are suspected to have narcolepsy – most patients with narcolepsy fall asleep in an average of less than 5 minutes during the MSLT.

VIDEO TELEMETRY EEG

EEG (Electroencephalograph) is a recording and monitoring of the electrical activity in the brain over a sustained period of time.

Video telemetry is used for:

- Diagnosing epilepsy (and the type of epilepsy)
- Epilepsy treatments and medications
- Diagnosing and differentiating seizures
- Syncope events
- Medication adjustments

SCREENING TOOLS – APNOEA LINK

An Apnoea Link is a diagnostic tool that records nasal pressure during sleep which can be used to screen for Obstructive Sleep Apnoea. The patient would come into London Bridge Hospital to have a short consultation to explain how each component of the link is fitted. The device is then taken home by the patient and worn whilst they are asleep. As the patient sleeps, the Apnoea Link records three channels of information:

- Oximetry
- Pulse
- Respiration

TREATMENTS:

CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)

Following the diagnosis of a sleep disorder such as Obstructive Sleep Apnoea, CPAP is often the most effective therapy for treating these disorders. These systems work on the principle of supplying positive air pressure through a tube and mask in order to hold open obstructed airways. These devices are designed to provide substantial symptomatic benefits to patients by allowing a more restful and uninterrupted sleep.

CPAP TITRATION

Traditionally, a CPAP Titration study involves an overnight, in-clinic evaluation of airway pressure requirements, resulting in a precise pressure prescription for your CPAP monitor. We can offer a second type of CPAP monitor that actually monitors airway requirements as the patient sleeps and automatically adjusts the pressure settings throughout the night, according to the individual's needs. This effectively eliminates the need for a formal overnight assessment. These monitors are referred to as APAP (Automatic Positive Airway Pressure) monitors and assessment or titration can be performed over a two-week trial period in the comfort of the patient's own home.



How Far can you Flex?

It sometimes seems that employment legislation appears to be going in a one-way direction – in favour of the employee. One such area is flexible working requests.

So what does the law say?

WHO CAN ASK FOR IT?

The law provides employees with the statutory right to request a flexible working pattern if they are:

- An employee, but not an agency worker
- Have worked for you for 26 weeks continuously before applying; and
- Have not made another application to work flexibly under the right during the past 12 months

AND

- Have or expect to have parental responsibility of a child aged under 18
- Have or expect to have parental responsibility of a disabled child under 18 who receives Disability Living Allowance (DLA)
- Are the parent/guardian/special guardian/foster parent/private foster carer or as the holder of a residence order or the spouse, partner or civil partner of one of these and are applying to care for the child
- Are a carer who cares, or expects to be caring, for an adult who is a spouse, partner, civil partner or relative; or who although not related, lives at the same address

WHAT PROCEDURE MUST AN EMPLOYEE FOLLOW?

If an employee has the statutory right to apply, then there is a process that they must follow.

The application must:

- Be made in advance of when they want it to take effect
- Be in writing (whether on paper or electronically)
- Be dated
- State that the application is made under the statutory right to request a flexible working pattern
- Give details of the flexible working pattern the employee is applying for, including the date from which they want it to start
- Explain what effect the employee believes the new working pattern would have on you, and how any effects might be dealt with
- State whether they have made a previous application and, if so, when

If any of these conditions are not met you do not have to consider the application at all. If an employee takes you to an Employment Tribunal for not considering an application, you could rely on the defence that the employee has failed to provide you with the required information.

IF THE REQUEST COMPLIES WITH THESE REQUIREMENTS YOU SHOULD TAKE THE FOLLOWING STEPS:

Step 1

Invite employee to meeting within 28 days.

Step 2

Advise employee of outcome within 14 days.

Step 3

Employee must appeal within 14 days.

Step 4

If employee appeals, hold meeting within 14 days.

Step 5

Confirm appeal outcome within 14 days.

SO WHAT'S THIS ALL ABOUT?

Documentation!
Documentation!
Documentation!

You need to be able to justify any decision you make objectively and be able to demonstrate the reasons for the decisions you take in an Employment Tribunal.

For further specific details on diagnostic observations and treatments available at the Sleep Centre or to book an appointment, please contact
T: 020 7234 2714.

New Outpatient Centres – World Class medical excellence is closer than you think

London Bridge Hospital's Outpatients Department provides access to experienced Consultants with expertise in all medical areas. Our facilities allow us to give advice, diagnosis and treatment within many specialties, extremely quickly. To help maintain this excellent level of service, we recently expanded our services and acquired three new Outpatient Centres from UME with Sevenoaks Medical Centre (Beadle House) and City of London Medical Centre (at Tower Hill) now being operated by London Bridge Hospital as an extension of the existing Outpatient Services we provide.

These centres will provide consultations and clinics across a wide range of specialist treatment and diagnostic services, as well as therapy services including dietetics and podiatry.

SEVENOAKS MEDICAL CENTRE

Sevenoaks Medical Centre will be the first centre to be re-launched under London Bridge Hospital ownership with patients being able to book appointments from mid-June 2011. The Sevenoaks Medical Centre has been designed to provide patients in Kent with quick access to outpatient clinics with appointments available on a same day or a next day basis.

Sevenoaks Medical Centre is able to provide a comprehensive range of clinical services including:

- Acupuncture
- Aesthetics
- Cardiology
- Counselling
- Dermatology

To find out more about Sevenoaks Medical Centre, please contact the centre on **T: 01732 775 800**, or to refer a patient to a clinic at Sevenoaks Medical Centre, please contact the GP Liaison Department on **T: 020 7234 2009**.

- ENT Surgery
- Gastroenterology
- General Surgery
- Gynaecology
- Hearing Aid Specialist
- Neurology
- Ophthalmology
- Oral & Maxillofacial Surgery
- Orthopaedics
- Osteopathy
- Physiotherapy
- Plastic Surgery
- Podiatry/Chiropody
- Psychiatry
- Rheumatology
- Urology

Below is a list of confirmed London Bridge Hospital Consultants who have clinics at Sevenoaks Medical Centre.

CONSULTANT AND SPECIALTY LIST AT SEVENOAKS MEDICAL CENTRE

Dr Richard Cooke	Cardiology
Ms Muriel Gall	Dietetics
Dr Martin Jones	General Practitioner & Acupuncturist
Dr John Crook	General Practitioner
Mr Frank Smedley	General Practitioner
Mr Omer Devaja	Gynaecology
Mr Andreas Papadopoulos	Gynaecology
Miss Shanti Raju	Gynaecology
Mr Bhupal Chitnavis	Neurosurgery
Dr Maarten Van Kets	Occupational Health
Mr Christopher Jenkins	Ophthalmology
Mr Andrew Lyons	Oral & Maxillofacial Surgery
Mr Sam Gidwani	Orthopaedics
Mr Paul Gill	Orthopaedics
Mr Graeme Groom	Orthopaedics
Mr Martin Klinke	Orthopaedics
Mr Tony Kochhar	Orthopaedics
Mr Jonathan Walczak	Orthopaedics
Mr Dimitri Yanni	Orthopaedics
Dr Jack Singer	Paediatrics
Dr Anthony Hammond	Pain Management
Dr Fariborz Neirami	Pain Management & Rheumatology
Mr Mike Brown	Physiotherapy
Dr Jeremy Broadhead	Psychiatry
Dr Adrian Winbow	Psychiatry
Dr Andrew Bamji	Rheumatology
Mr Gordon Muir	Urology
Mr Rick Popert	Urology

NB: Consultant List correct at time of printing.

CITY OF LONDON MEDICAL CENTRE

City of London Medical Centre is a diagnostic and treatment centre which offers a wide range of diagnostic and treatment services based in an easily accessible central London location.

The centre has a specialist team of experienced staff which ensures the very highest quality of medical standards and efficient service throughout the patient's visit.

City of London Medical Centre is able to provide consultations and treatments in the following areas:

- Dermatology
- ENT
- Gynaecology
- Neurology
- Neurosurgery
- Orthopaedics
- Sports Medicine

THERAPY

- Hand Therapy
- Podiatry

To find out more about City of London Medical Centre, please contact the centre on **T: 020 7488 5060**, or to refer a patient to a clinic at City of London Medical Centre, please contact the GP Liaison Department on **T: 020 7234 2009**.

Below is a list of confirmed London Bridge Hospital Consultants who have clinics at City of London Medical Centre.

CONSULTANT AND SPECIALTY LIST AT CITY OF LONDON MEDICAL CENTRE

Dr Anshoo Sahota	Dermatology
Mr Nicholas Eynon-Lewis	ENT
Dr Ross Perry	General Practitioner
Mr Bijendra Patel	General Surgery
Mr Joe Onwude	Gynaecology
Miss Katherine Butler	Hand Therapy
Mrs Lucy Green	Hand Therapy
Dr Giles Elrington	Neurology
Dr Michael Rose	Neurology
Mr Brian Cohen	Orthopaedics
Dr Colin Crosby	Sports Medicine
Dr Paul Jackson	Sports Medicine
Dr Usamah Jannoun	Sports Medicine
Dr Dominic Radford	Sports Medicine

NB: Consultant List correct at time of printing.

DIAGNOSTIC IMAGING

The Consultants at City of London Medical Centre are also supported by state-of-the-art diagnostic imaging equipment to provide fast and accurate assessment and to help determine the best possible treatment options to patients.

The imaging services provided at City of London Medical Centre are:

- General X-ray
- MRI – performed by experienced radiographers using a 1.5 Tesla Magnet (Phillips)
- OPG Dental X-ray
- Ultrasound

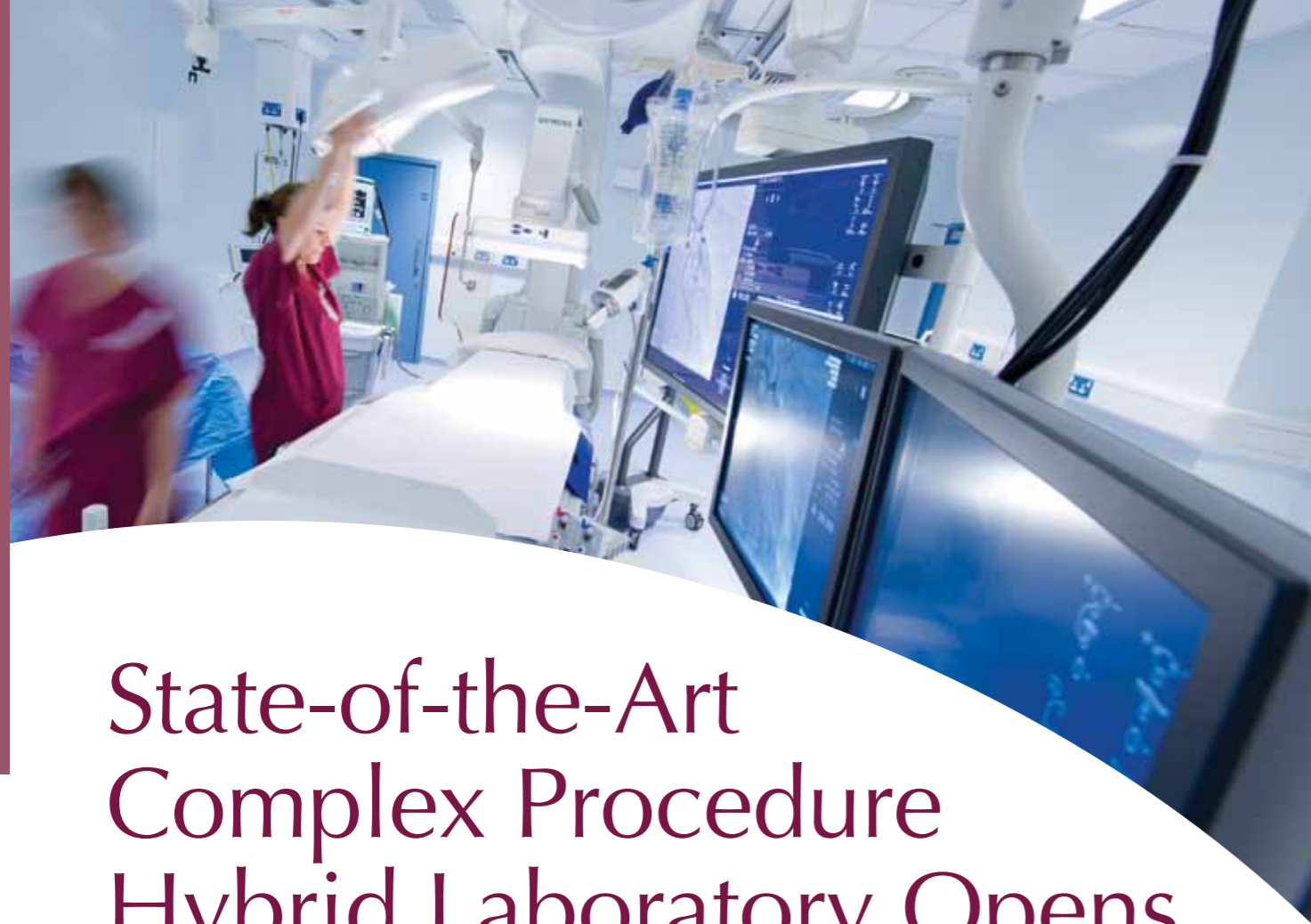
Patients using these services will benefit from quick analysis and results reporting, in most cases, results are made available to referring Consultants and GPs within 24-48 hours for feedback to patients.

A London Bridge Hospital
Consulting and Treatment Centre

Sevenoaks Medical Centre
Beadle House

A London Bridge Hospital
Diagnostic and Treatment Centre

City of London Medical Centre



State-of-the-Art Complex Procedure Hybrid Laboratory Opens at London Bridge Hospital

One of the UK's first hybrid laboratories for complex procedures has been opened at London Bridge Hospital. The new £1.2 million laboratory can be used to image any part of the body and facilitates complex cardiac, liver-related (HPB), orthopaedic and many other procedures.

The hybrid lab is part of a £15 million expansion and reconfiguration programme at the hospital which has also created two new operating theatres, a new Critical Care Unit and a number of new patient rooms and other patient and staff facilities.

London Bridge Hospital has an international reputation for innovative and complex procedures, in particular in the areas of cardiac, HPB, orthopaedic medicine and others requiring a range of interventional radiological procedures. The state-of-the-art Siemens technology in the hybrid lab enables simultaneous displays of live imaging and matching 3D reconstruction to facilitate guidance during complex interventions.

There are also dose saving features including a laser positioner and a last image hold positioner with displays on a 56-inch monitor that can be configured into different sections tailored to each case.

Any part of the body can be imaged and the procedures that will be undertaken will initially include portal vein embolisations, TIPPS, vertebroplasty, kyphoplasty, TAVI, coronary angioplasty, liver TACE and fitting cardiac pacemakers.

Chief Executive Officer of London Bridge Hospital, John Reay, said the new laboratory was an important addition to the state-of-the-art facilities at the hospital.

“This hospital has long had a reputation for introducing the latest techniques and technology and it has often been first to provide new services for private patients,”

he said. “For example, we were the first private hospital to carry out minimally invasive heart valve repairs; the first to install 64 slice CT imaging technology, the first to develop dual ablation procedures for arrhythmias and the first to carry out the TAVI procedure in the private sector.

“Our hybrid lab is another first and it will bring major benefits for patient care in a wide range of disciplines. This, together with the other new facilities including a new 15-bed Critical Care Unit with 8 level three ICU beds, will emphasise our hospital's position as one of the country's leading private tertiary hospitals,” said Mr Reay.

Consultant interview

10 minutes with...

Mr Constantinos Kyriakides,
Consultant Vascular and Endovascular Surgeon

1. Why did you decide to study medicine?

Medicine runs in my family. It all started with my grandfather, who made a big impression on me when I was young. He was a doctor and I saw how appreciative people were when they visited his practice after being treated. In addition, following advances in medicine through the media as a child only reinforced my desire to study medicine.

2. What made you pursue your specialty?

Whilst training as a junior doctor in Manchester, I worked for an inspirational vascular surgeon who enhanced my desire to pursue my chosen specialty.

Also, the rapidly increasing technological advances in vascular surgery simply strengthened my conviction to further my career in the field of cardiovascular intervention.

3. What is the most rewarding part of your job?

Seeing grateful and happy patients following their treatment fills one with an unbelievable sense of achievement.

4. What do you enjoy doing in your spare time?

When I do have some spare time I enjoy playing five-a-side football and squash, which tends to be on Sunday mornings. I also enjoy going to the theatre.

5. What is the title of your best read so far?

I mainly read medical journals but one of my all time favourites has to be 'The

Art of The Deal' by Donald Trump. It reinforced my belief that great things come out of good teamwork and choosing the team of people around you is of paramount importance.

6. If you could invite three people to dinner, living or dead, who would they be?

Michael DeBakey – I am very curious how one man can come up with so many inventions and in a lifetime revolutionising the area of cardiovascular surgery. Dr Christian Bernard, the South African surgeon who performed the first successful human heart transplant, and Salvador Dali, being such a fan of art myself, I am fascinated by how he came up with the ideas for some of his most outstanding work.

7. What is special about where you grew up?

I grew up in Cyprus so I had the sun and the sea but the thing that was special for me was the close-knit community spirit and the security and support that it offered.

8. Where is your favourite place in the world?

Italy – it offers some of the best food and wine and also makes some of my favourite cars.

9. Who would you get to play yourself in a movie?

Harrison Ford as Indiana Jones because working in medicine every day is an adventure.



Mr Constantinos
Kyriakides

Consultant Vascular and
Endovascular Surgeon

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Mr Kyriakides is a Fellow of The Royal Colleges of Surgeons of England and Edinburgh, Vascular Society of Great Britain and Ireland, European Society of Vascular Surgery and Association of Surgeons of Great Britain and Ireland.

He qualified from Manchester University in 1991. He trained at Manchester, Brigham Women's Hospital, Harvard Medical School and St Mary's Hospital London. In 2003, he was appointed Consultant Vascular and Endovascular Surgeon at Bart's and The London NHS Trust and is currently the Lead Clinician. In 2006, he was appointed Honorary Senior Lecturer to the University of London.



Physiotherapy at London Bridge Hospital

The Physiotherapy Department at London Bridge Hospital, working closely with a variety of surgeons and physicians, is a team of physiotherapists highly specialised in musculoskeletal and sports injuries, neurology and cardiorespiratory conditions.

The multi-disciplinary team within the Department has a close relationship with all of the hospital's Consultants, providing a uniquely integrated approach to patient care and ensuring seamless cross-referral pathways where required.

The Inpatient and Outpatient therapists are fully integrated, therefore giving patients who attend the hospital in both guises a feel of familiarity and consistency.

A full comprehensive initial assessment is always undertaken with a wide range of treatments available. Whether the patient needs treatment of an acute injury, video analysis of their gait or cycling technique, sports specific rehabilitation or management of long-term pain, our physiotherapists

have the skills and facilities to accommodate them.

We are also developing a Cognitive Behavioural Therapy service to further enhance our provision for chronic lower back pain patients.

Physiotherapy at London Bridge Hospital is recognised by major insurance companies, therefore allowing ease of access for patients in arranging their funding. However, we advise you to check with your insurers before undergoing treatment. Competitive self pay prices are also available.

The Department is constantly growing and developing new services and enquires are always welcome.

Our physiotherapists are also available to give talks, education evenings or any CPD requirements that GPs especially may find useful in any of the areas above.

The Department can be contacted on:

T: 020 7234 2500
F: 020 7234 2815

Paul McGaughey, Acting Manager and Shalini Clark, Deputy Manager can be contacted directly on the email addresses below, especially regarding visits to practices:

paul.mcgaughey@hcahealthcare.co.uk
shalini.clark@hcahealthcare.co.uk

GP Liaison – Making Referrals Even Easier

Liaising with GPs, Consultants and their secretaries, and the patient, the GP Liaison Team provides a bespoke service organising timely and convenient appointments at London Bridge Hospital and its outpatient centres.

Our GP Liaison Team's aim is to provide hassle free access to the specialist services available at London Bridge Hospital. Getting in touch with GP Liaison couldn't be easier; just contact us by one of the options outlined below and we will do the rest:

T: 020 7234 2009
F: 020 7234 2019
gpliaisonlbh@hcahealthcare.co.uk

In GP Liaison we listen to our GPs' needs and are driven to make our service the best and easiest that it can be. To enhance our service, we have recently added an online appointment form to the London Bridge Hospital website. This gives GPs and patients the ability to request appointments at London Bridge Hospital 24 hours a day, 7 days a week.

*Are you the patient? Yes

*Surname:

*Forename:

Gender: Male

*Date of Birth:

*Email:

*Postcode:

*Tel no (home):

*Mobile:

Is the patient: Insured

*Required Specialty:

Preferred Consultant(s) (if known):

*Brief history / reason for referral:

(Completing this section will enable us to direct your enquiry to the most appropriate Consultant)

*Preferred appointment date:

*GP Referral: Yes

*GP Name:

*GP Surgery:

Please enter the word you see in the image below:

Just visit www.londonbridgehospital.co.uk, click on the 'make an appointment' button and complete the appointment request form shown above.

Once you have submitted your appointment request, a member of the GP Liaison Team will contact you to confirm your booking.

